

8033

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City RFD 4		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City RFD 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 40		d. STREET ADDRESS Route 40	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle LEE Last CARTER		4. DATE OF DEATH Month July Day 19 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-1874
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lemuel C. Carter		14. MOTHER'S MAIDEN NAME Alfredda Carson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Lottie Critzer, Ellicott City, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Arteriosclerotic Cardio-Vascular Disease INTERVAL BETWEEN ONSET AND DEATH 5 days 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1953 , to July 19, 1958 , that I last saw the deceased alive on July 12, 1958 , and that death occurred at Ellicott City, Md. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Ellicott City, Md. 7-19-58			
ACTUAL SIGNATURE William T. Garrison		PHYSICIAN'S NAME (Type) Ellicott City, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-21-58	
22c. NAME OF CEMETERY OR CREMATORY Family		22d. LOCATION (City, town, or county) (State) Covington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.		24. REC'D BY REGISTRAR DATE JUL 21 '58	
25. REGISTRAR'S SIGNATURE W. L. Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8034

CERTIFICATE OF DEATH

08032

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Alpha		d. STREET ADDRESS 1 Alpha	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last SEBASTIAN BROWN CISSEL Sr.		4. DATE OF DEATH Month Day Year July 6, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-1884
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Gen. Mdse	
11. BIRTHPLACE (State or foreign country) Highland, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wilbur F. Cissel		14. MOTHER'S MAIDEN NAME Clara Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT S. Brown Cissel, Marriottsville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 6, 1958 , to July 6, 1958 , that I last saw the deceased alive on June 12, 1958 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Thomas J. Herbert M.D. 46 Church Rd		7/7/58	
PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.		Ellicott City, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-9-58	22c. NAME OF CEMETERY OR CREMATORY Mt. View	22d. LOCATION (City, town, or county) (State) Alpha, Md
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE JUL 8 '58	
		24b. REGISTRAR'S SIGNATURE Alfred Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934

MASS. REG. NO.

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Handwritten entries and signatures in the form fields, including names, dates, and official stamps.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>	
c. LENGTH OF STAY IN 1b <u>12 yrs</u>		d. STREET ADDRESS <u>Route 175</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 175</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sarah Estelle Sims</u>		4. DATE OF DEATH <u>July 29 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1884</u>
9. AGE (in years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Seneca, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Sewell Clark</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Gardner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Mrs. Olive Bernaman, Jessup, Md</u>		Address <u>_____</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio</u> DUE TO <u>Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>_____</u> DUE TO (c) <u>_____</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1st 1956</u> to <u>July 29 1958</u> , that I last saw the deceased alive on <u>July 29 1958</u> and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Savage, Md.</u>	
ACTUAL SIGNATURE <u>Frank E Shipley</u> M.D.		DATE SIGNED <u>7/30/58</u>	
PHYSICIAN'S NAME (Type) <u>FRANK E SHIPLEY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 31, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Friendship, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Conaldson, Laurel, Md</u>		24a. REC'D BY REGISTRAR <u>_____</u> ADDRESS <u>_____</u>	
24b. REGISTRAR'S SIGNATURE <u>_____</u>		DATE <u>AUG 5 '58</u>	

MADE IN U.S.A.
FOLD OVER

DEATH CERTIFICATE

NO. 100-1000

CERTIFICATE OF DEATH

U.S. DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED		SEX		AGE	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
DATE OF DEATH		PLACE OF DEATH		CITY	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN	
DATE		PLACE		CITY	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8036 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08034

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

I

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland XXXXXXXXXXXX b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harmans 02X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Universal Concrete Pipe Co.		d. STREET ADDRESS 2-Hanford Drive	
3. NAME OF DECEASED (Type or print) LEE First Middle Last		4. DATE OF DEATH July 21, 1958 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1922
9. AGE (in years last birthday) 35 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Un' Pipe Co.	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mike Fader (Dec)		14. MOTHER'S MAIDEN NAME Ruth Unknown (Dec)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) War 11		16. SOCIAL SECURITY NO.	
17. INFORMANT Mike Fador- Harmans, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound Comminuted Skull Fracture 9/2.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Instant	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Block struck victim in head Boom on crane buckled while lifting large concrete pipe	
20c. TIME OF INJURY Month, Day, Year 5:20 PM 7-21-58 19	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Factory	20f. (City or town) (County) (State) Jessups Howard Md
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Donald E. Fisher M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Donald E. Fisher M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 24, 58	
22c. NAME OF CEMETERY OR CREMATORY River View Cemetery		22d. LOCATION (City, town, or county) (State) Apollo - Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE R. R. Singleton - Glen Burnie		24a. REC'D BY REGISTRAR DATE JUL 25 '58	
		24b. REGISTRAR'S SIGNATURE Alb. Leach	

YOUR MEDICAL EXAMINER'S CERTIFICATE OF DISABILITY

DATE OF EXAMINATION

UNITED STATES DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C. 20315

1. NAME (Last, first, middle initial)
2. GRADE OR RATE
3. BRANCH
4. ORGANIZATION
5. ADDRESS
6. CITY
7. STATE
8. ZIP CODE

9. DATE OF BIRTH
10. SOCIAL SECURITY NUMBER
11. SERVICE NUMBER
12. GRADE OR RATE
13. BRANCH
14. ORGANIZATION
15. ADDRESS
16. CITY
17. STATE
18. ZIP CODE

19. DATE OF EXAMINATION
20. NAME OF PHYSICIAN
21. ADDRESS
22. CITY
23. STATE
24. ZIP CODE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8037 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08035

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup (Rural)</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Jessup (Rural)</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George</u> First <u>Rice</u> Middle <u>Hickman</u> Last				4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1890</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General construction</u>		11. BIRTHPLACE (State or foreign country) <u>Hawkins Co., Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Hickman</u>				14. MOTHER'S MAIDEN NAME <u>Emmie Conk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Annie Hickman, Jessup, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive vascular disease</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>2 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>George E. Burgtorf</u> EXAMINER'S NAME (Type) <u>George E. Burgtorf</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>July 3, 1958</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 5, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Savage Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Savage, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Donaldson</u> ADDRESS <u>Laurel Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Donaldson</u>	

FOR STATE
HEALTH DEPT.

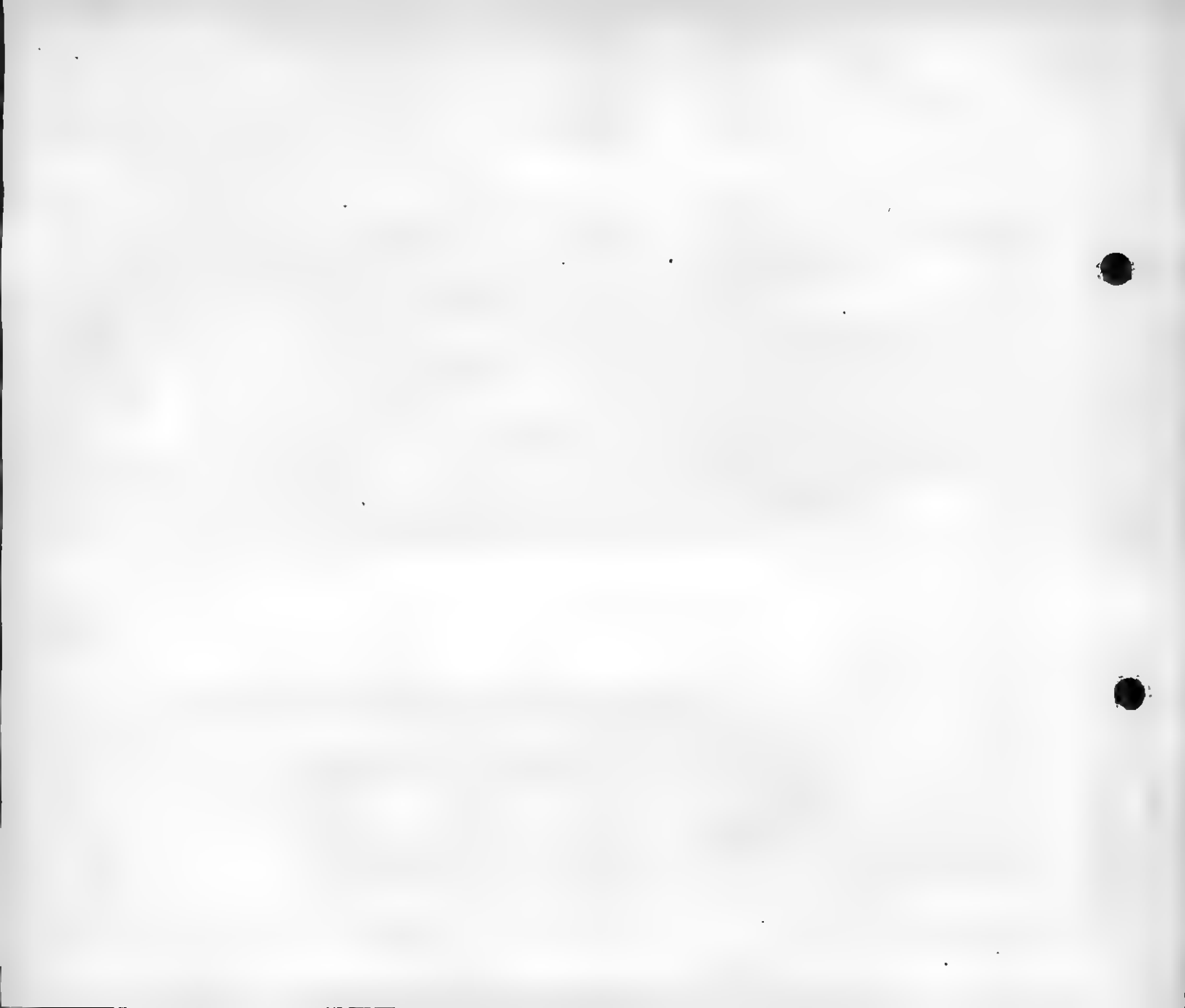
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
6M 2157

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08038
8038 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HOWARD CO.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>HOWARD CO.</u> COUNTY <u>MD.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u>		c. LENGTH OF STAY IN TB <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>High Ridge Rd.</u>			f. STREET ADDRESS <u>High Ridge Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>MAURICE R. HOOPER</u>			4. DATE OF DEATH <u>7/2/58</u>		Year <u>19</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/9/900</u>		9. AGE (In years last b. birthday) <u>58</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Metal Seal Co</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>MAURICE R. HOOPER</u>			14. MOTHER'S MAIDEN NAME <u>CATHERINE</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>MRS. MARGARET A. HOOPER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>					
420.1 DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerotic Cardio-Vascular Disease</u>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>George E. Burgtorf</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7/3/58</u>	
EXAMINER'S NAME (Type) <u>GEORGE E. BURGTORF M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>7/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LODGEN PARK</u>	
				22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Nabb & Son</u>		ADDRESS <u>CATONSVILLE 28 MD</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 7 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05037

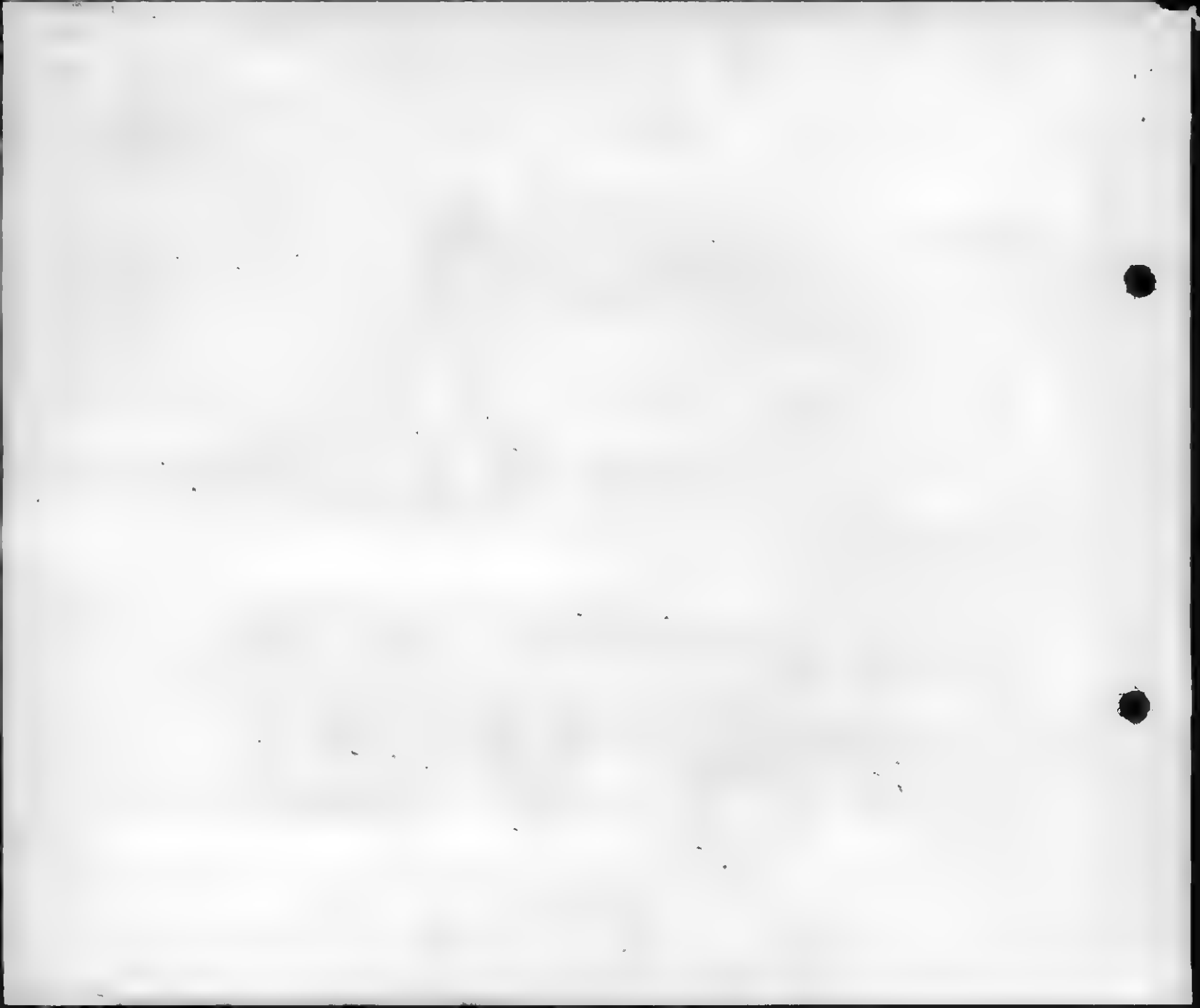
Item 1 Dr. Fisher 8-20-58

8039

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Haward</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>md</i> b. COUNTY <i>it</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Odenton rural</i>				c. LENGTH OF STAY IN 1b <i>Life</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>XXXXXX XXXXX XXXXX</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Loretta - Long</i>				4. DATE OF DEATH <i>July 27 1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>64</i> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Haward Co md</i>	
13. FATHER'S NAME <i>Charles Z. Thomas</i>				14. MOTHER'S MAIDEN NAME <i>Drenda Griffin</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>				16. SOCIAL SECURITY NO <i>XXXXXX XXXX</i>		17. INFORMANT <i>Thomas M Long</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardio Vascular</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>1</i>			
20c. TIME OF INJURY Month <i>6</i> Day <i>19</i> Year <i>19</i> Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1</i>		20f. (City or town) <i>1</i> (County) <i>1</i> (State) <i>1</i>	
21. I certify that I attended the deceased from <i>4-24-58</i> to <i>7-27-58</i> and that death occurred at <i>2:4</i> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Joseph Lipskey</i>				DATE SIGNED <i>7-30-58</i>			
PHYSICIAN'S NAME (Type) <i>DR. JOSEPH LIPSKY</i>				ADDRESS (Street, city or town, state) <i>Odenton md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-30-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>West Liberty md</i>		22d. LOCATION (City, town, or county) (State) <i>Howard County md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Choy O. Wilson</i>				24a. REC'D BY REGISTRAR <i>1000. S. Montague Ave.</i>		24b. REGISTRAR'S SIGNATURE <i>1000. S. Montague Ave.</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8040

CERTIFICATE OF DEATH

08038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kerger Road				d. STREET ADDRESS Kerger Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM GEORGE MARTIN				4. DATE OF DEATH Month Day Year July 11, 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-3-1892	
9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR Months Days Hours Min. 19		IF UNDER 24 HRS. 19			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Electrical		11. BIRTHPLACE (State or foreign country) London, England	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME George Martin				14. MOTHER'S MAIDEN NAME ? Capstock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-07-3424		17. INFORMANT Address Mrs. Alice A. Martin, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF URINARY BLADDER DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CARCINOMA, LIVER, LUNGS DUE TO (c) PULMONARY EMPHYSEMA							INTERVAL BETWEEN ONSET AND DEATH 27.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 8:11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 15 APRIL, 1954 to 11 JULY, 1958 , that I last saw the deceased alive on 7 JULY, 1958 , and that death occurred at 8:11 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald E. Fisher M.D.				ADDRESS (Street, city or town, state) Ellicott City, Md. 7-12-58			
PHYSICIAN'S NAME (Type) DONALD E. FISHER M.D. ELLICOTT CITY MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 7-14-58		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.				24a. REC'D BY REGISTRAR JUL 15 58		24b. REGISTRAR'S SIGNATURE W. H. Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4. may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. This certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05039

8041 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Haward</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Haward</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Laurel</i>		<i>11 years 41</i>		TOWN <i>Laurel</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Baltimore Blvd</i>				STREET ADDRESS (If rural give location) <i>Baltimore Blvd</i>			
3. NAME OF DECEASED (Type or Print) <i>Living Jennings Perkins</i> (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <i>July 6 1958</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>April 15 1895</i>		9. AGE last birthday <i>63</i> yrs.		10. IF UNDER 1 YEAR (Months) (Days) <i>10 58</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>unknown</i>				14. MOTHER'S MAIDEN NAME <i>unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>unknown</i>		16. SOCIAL SECURITY NO. <i>218-05-5012</i>		17. INFORMANT & ADDRESS <i>Mrs Margaret Perkins Laurel</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
434.1 IMMEDIATE CAUSE (A) <i>Pericardial Effusion</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary artery disease</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Heart Failure</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 19 58, to July 5 58, that I last saw the deceased alive on July 5 58, and that death occurred at 10:30 AM, from the causes and on the date stated above.							
SIGNATURE <i>John P. King</i> M.D.				DATE SIGNED <i>July 6 1958</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>July 8 1958</i>		NAME OF CEMETERY OR CREMATORY <i>Linthicum Chapel</i>		LOCATION (City, town, or county) <i>Clarksville Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>John P. King</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Del With</i>		ADDRESS <i>Sanatdon Laurel Md</i>	
DATE <i>JUL 10 '58</i>							

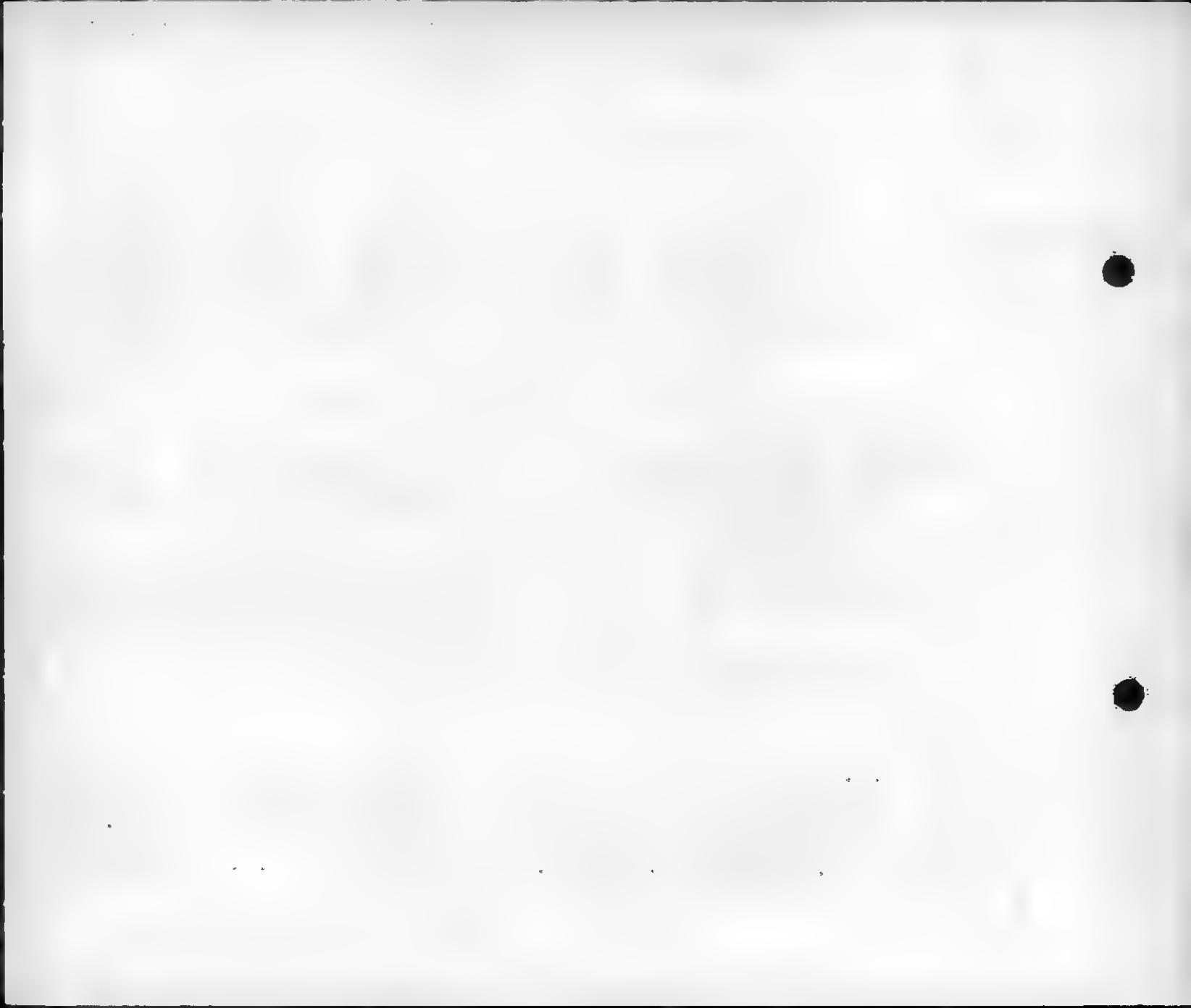


8042 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shepherdsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shepherdsville</u>	
c. LENGTH OF STAY IN 1b <u>40 years</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>I</u> Last <u>RENEHAN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1877</u>
9. AGE (in years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Selby</u>		14. MOTHER'S MAIDEN NAME <u>Mary Himes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT <u>Mr. Sydney Renahan, Sykesville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma of right parotid gland</u> <u>142.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1935</u> , 19____, to <u>7.7.58</u> , 19____, that I last saw the deceased alive on <u>7.7.58</u> , 19____, and that death occurred at <u>12:01 P.M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>Liberty Road at Eldersburg</u> <u>7.7.58</u>	
PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr.,</u>		M.D. <u>Sykesville, P.O., Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-9-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Catholic</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>		ADDRESS <u>Sykesville, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's office, page 3 should be detached for use with the burial-transit permit. Then please remove carbon papers, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8043

CERTIFICATE OF DEATH

08041

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. LENGTH OF STAY IN 1b <u>41 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give name of place where deceased died) <u>Shaffers Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>MARY</u> First <u>RUPPERT</u> Middle <u>JO</u> Last		DATE OF DEATH <u>JULY 25</u> 19 <u>58</u> Day Month Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 14, 1899</u> 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Richmond, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Wadges (Wadsworth)</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Duker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Mrs Marie Reck Jessup, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO (b) <u>Carcinoma of Breast, Rt</u> DUE TO (c) <u>14H.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>about 4 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-14</u> 19 <u>58</u> , to <u>7-25</u> 19 <u>58</u> , that I last saw the deceased alive on <u>7-25</u> 19 <u>58</u> , and that death occurred at <u>7:15</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jose M. Yosvico</u> M.D.		ADDRESS (Street, city or town, state) <u>RFD #1 Jessup, Md.</u> DATE SIGNED <u>7-25-58</u>	
PHYSICIAN'S NAME (Type) <u>JOSE M. YOSVICO</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>July 28, 1958</u>	<u>Madamridge New Park</u>	<u>Danvers, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Connelley</u> ADDRESS <u>Danvers, Md</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <u>JUL 30 '58</u>	<u>Alfred Smith</u>



CERTIFICATE OF DEATH

Reg. Dist. No.

08042

8044

1. PLACE OF DEATH a. COUNTY HOWARD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Jefferson	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Charles Town	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION TAYLOR MANOR HOSPITAL		d. STREET ADDRESS 85X-3	
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD CARROLL SMITH		4. DATE OF DEATH Month Day Year July 31 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 18, 1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter Retired		10b. KIND OF BUSINESS OR INDUSTRY Keyser W. Va.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dennis Oliver Smith		14. MOTHER'S MAIDEN NAME Rebecca Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 175-07-0518	
17. INFORMANT Mrs. Elmer Wageley, RFD Charles Town, W. Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Anteriosclerosis generalized, severe (c) Unknown INTERVAL BETWEEN ONSET AND DEATH 1 hour		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 17, 19 58 , to July 31, 19 58 , that I last saw the deceased alive on July 31, 19 58 , and that death occurred at 8:30 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Irving J. Taylor		DATE SIGNED 7-31-58	
PHYSICIAN'S NAME (Type) IRVING J. TAYLOR MD		ADDRESS Taylor Manor Hosp., Ellicott City, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-2-58	22c. NAME OF CEMETERY OR CREMATORY Edge Hill	22d. LOCATION (City, town, or county) (State) Charles Town W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.		24a. REC'D BY REGISTRAR DATE AUG 4 '58	
24b. REGISTRAR'S SIGNATURE W. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

525

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8045 CERTIFICATE OF DEATH

08043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u> Md </u> b. COUNTY <u> Howard </u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Jessup</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Jessup</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Blvd</u>		d. STREET ADDRESS <u>Washington Blvd</u>	
3. NAME OF DECEASED (Type or print) <u>Emile</u> First <u>Thys</u> Middle <u>Thys</u> Last		4. DATE OF DEATH <u>July</u> Month <u>11</u> Day <u>1958</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1899</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>matchmaker & operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>match</u>	
11. BIRTHPLACE (State or foreign country) <u>Belgium</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Thys</u>		14. MOTHER'S MAIDEN NAME <u>Louise Van Der Auvera</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>092-10-9449</u>	
17. INFORMANT <u>June Gavis Thys</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>March 29, 1958</u> to <u>July 11, 1958</u> , that I last saw the deceased alive on <u>July 11, 1958</u> and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Thomas R. Mazzocco</u>		DATE SIGNED <u>320 MONTGOMERY, LAUREL, Md.</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS R. MAZZOCCO</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>July 14, 1958</u>	<u>St Marys Cem.</u>	<u>Laurel Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>He Witt Dandelion</u>		24a. REC'D BY REGISTRAR <u>W. H. Smith</u>	24b. REGISTRAR'S SIGNATURE
ADDRESS <u>Laurel Md</u>		DATE <u>JUL 16 '58</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM
JAMES
MCDONALD
JAN 1901

Form with multiple lines for text entry, including fields for name, date, and other details. The text is faint and mostly illegible.